STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
Heritage Place Metro Center
227 French Landing Suite 300
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 532-3202 OR 1-800-778-4123
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE AS REGISTERED RESPIRATORY THERAPIST (RRT) OR CERTIFIED RESPIRATORY THERAPIST (CRT OR CRTT)
LICENSURE APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

Done

1. Complete, sign, have notarized and mail the application pages 1 through 6. _____
2. Complete and mail **Attachment 1** along with a check or money order to the National Board of Respiratory Care. _____
3. Complete and mail **Attachment 2** to each state, county, or province in which you hold, or have ever held, a license to practice any profession. _____
4. Complete and mail **Attachment 3** to the school at which you completed your respiratory care educational/training program. _____
5. Attach to the application a clear, recognizable, full faced passport style photograph of yourself. (sized between 2x2 & 4x4) Computer generated images are not acceptable. _____
6. Submit with the application, a check or money order in U.S. funds in the amount of $120.00, made payable to the State of Tennessee. (If applying for an upgrade as listed in #7, this fee is not applicable.) _____
7. If licensed in the state of Tennessee as a certified Respiratory Therapist (CRT or CRTT) and wish to upgrade to a Registered Respiratory Therapist (RRT) submit with the application, a check or money order in U.S. funds in the amount of $30.00 made payable to the State of Tennessee. _____
8. Complete and return the Mandatory Practitioner Profile. This must be completed before licensure can be considered. _____
9. Criminal Background Check. **To obtain instructions for a criminal background check, click here.** _____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

Board of Respiratory Care
Heritage Place Metro Center
227 French Landing Suite 300
Nashville, TN 37243

For Federal Express or Special Courier:
Board of Respiratory Care
Heritage Place Metro Center
227 French Landing Suite 300
Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. **We will discuss application status with the applicant or applicant's spouse only**. Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.

5. If all necessary documentation has not been received when your application is received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

6. **Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.**

7. It is recommended that you do not make arrangements to accept employment as a Respiratory Care Practitioner in Tennessee until you are granted a license, temporary permit or temporary license by the Board of Respiratory Care.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have either a Tennessee License or a Board issued authorization in your possession before you may lawfully practice as either a Registered or Certified Therapist.

ATTACH A CURRENT PASSPORT STYLE PHOTOGRAPH

3747-001	$110.00
3747-006	$ 10.00
3750-001	$110.00
3750-006	$ 10.00
3747 upgrade-001	$ 20.00
3747 upgrade-006	$ 10.00

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BOARD OF RESPIRATORY CARE
(615) 532-3202 or Toll Free 1-800-778-4123
LICENSURE APPLICATION

Choose the appropriate certificate category and any endorsements for which you qualify within the category. See the Practice Act and the Rules and Regulations to determine the requirements for each category of practitioner.

LICENSURE ALTERNATIVES

LICENSURE REQUEST	For Office Use Only
A. _____ Registered Therapist	_____ License Qualified _____ Temporary License Qualified _____ Temporary Authorization _____ ABG Endorsement Qualified
B. _____ Upgrade from Certified Therapist to Registered Therapist	_____ License Qualified _____ Temporary License Qualified _____ Temporary Authorization _____ ABG Endorsement Qualified
C. _____ Certified Therapist	_____ License Qualified _____ Temporary License Qualified _____ Temporary Authorization _____ ABG Endorsement Qualified

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name _____
Last **First** **Middle** **Maiden**

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____

Mailing Address: _____ County (TN Applicants Only): _____

_____

_____ Phone: Home: (_____) _____

_____ Office: (_____) _____

Place of Birth: _____ Sex (optional-for statistical purposes only)

Female _____

U.S. Citizen: Yes _____ No _____ Male _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

List the education you graduated from for your respiratory care training. Please provide the following information for all educational institutions you have attended.

From:_______ To: _______ ______________________________ ________________
Mo/Yr Mo/Yr Educational Institution/Respiratory Care City State

From:_______ To: _______ ______________________________ ________________
Mo/Yr Mo/Yr Educational Institution/Respiratory Care City State

Please complete your entire Respiratory Care employment history starting with the most current position first. Use the back of this page if you need additional space. Explain any gaps in employment.

DATES	**LOCATION**	**EMPLOYER, POSITION, AND DUTIES**
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________
From: _______ To: _______ Mo/Yr Mo/Yr	____________________ (City) (State)	Employer ______________ Position ______________ Duties ______________

LICENSURE INFORMATION

List below **ALL STATES, COUNTRIES OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED OR CERTIFIED** as a Respiratory Care Practitioner. Submit a copy of **Attachment #2** to all such States, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification or permit as a health professional other than a Respiratory Care Practitioner. Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		Yes	No
1.	Are you certified (CRT or CRTT) by the National Board for Respiratory Care? If so, complete **Attachment #1** and send it to the NBRC.	____	____
2.	Are you registered (RRT) by the National Board for Respiratory Care? If so, complete **Attachment #1** and send it to the NBRC.	____	____
3.	Have you ever applied for a Respiratory Care license or certificate in Tennessee? ( ) Assistant ( ) Certified Therapist ( ) Registered Therapist	____	____
4.	Have you ever received a Respiratory Care temporary permit, certificate, or license in Tennessee.	____	____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to any questions in this part are in the affirmative, attach an explanation on a separate sheet. *In support of your explanation, the final documents or orders from the issuing states, or agencies must be submitted along with this application.*

For the purposes of these questions, the following phrases or words have the following meanings.

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary) and exercise reasoned judgments and to learn and keep abreast of developments in your profession; and

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers, and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

3. **Chemical substances"** is to be construed to include alcohol, drugs or medication, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety.	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice.	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:		YES	NO
2.	Do you currently use chemical substances as defined on page 4?	_____	_____
	a. Please list: Name _____ Name _____	_____	_____
	b. If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
3.	Are you currently engaged in the illegal use of controlled substances?	_____	_____
	a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice Respiratory Care in any state, county or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat or restriction of disciplinary action?	_____	_____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8.	Have you ever been rejected or censured by a professional society?	_____	_____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
	b. Have you ever had settlement of any legal action rendered <u>against y</u>ou, or	_____	_____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
10.	If you have ever held a license or certificate in any health care profession, has it ever be reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn
(Applicant's Name) (City) (State)

and identified as the person referred to in this application, attests to the truth of each statement made in said application, I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of respiratory care in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board or Board interview;

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice respiratory care;

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification;

ACKNOWLEDGE that I, as an applicant for certification or licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me, this _____ day of _____, 20_____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires _____

ATTACHMENT #1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
Heritage Place Metro Center
227 French Landing Suite 300
NASHVILLE, TN 37243

NBRC VERIFICATION

If you are certified or registered by the NBRC, please complete the top portion of this form and mail it to the address below. You must include a check or money order for $5.00 made payable to the NBRC. (If you are not an active member of the NBRC, the charge is $20.00).

Send to:

The National Board of Respiratory Care, Inc.
8310 Nieman Road
Lenexa, Kansas 66214

To Be Completed By Applicant (Please Print In Ink)

Dear NBRC Official:

I am applying for a License to practice respiratory care in the State of Tennessee. The State Board of Respiratory Care requires that a credential letter be forwarded directly to their office by the NBRC.

Applicant's Name _____
(First) (M.I.) (Last)

Social Security No. _____ - _____ - _____

To Be Completed by NBRC

Name applicant credentialed by if different from above:

_____
(First) (M.I.) (Last)

Complete all that apply: Date Certified (CRTT or CRT) - _____

Date Registered (RRT) - _____ Registry No. _____

_____
(NBRC Official's Signature)

Please mail directly to: **Board of Respiratory Care**
Heritage Place Metro Center
227 French Landing Suite 300
Nashville, TN 37243

ATTACHMENT #2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
Heritage Place Metro Center
227 French Landing Suite 300
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 532-3202
1-800-778-4123
CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license / certificate / registry to practice _____ with **(check one)** ❒License ❒Certificate ❒Registry number _____
(Profession)
on (Date)_____ in the State of _____.
The Board of Respiratory Care of Tennessee requests that I submit evidence of the current status of the license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Respiratory Care.

Date: _____ _____
Applicant's Signature

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As It Appears On License/Certificate or Permit:
_____

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____

Basis of issuance _____ Endorsement/Reciprocity with _____
(Check One) (State)

_____ Written Examination _____

The License is currently active and registered? _____ Yes _____ No

Is there any derogatory information on file? _____ Yes _____ No
If yes, Please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

PH 3117 RDA S836-1
Rev. 06/06

ATTACHMENT #3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
Heritage Place Metro Center
227 French Landing Suite 300
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 532-3202
1-800-778-4123
EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your respiratory care educational program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a respiratory care practitioner in the State of Tennessee. The Board of Respiratory Care requires verification of educational attainment. Please forward an original transcript, identifying The Respiratory Care completion date and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____
_____
_____
_____

Applicant's Social Security Number: _____-_____-_____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Board of Respiratory Care
Heritage Place Metro Center
227 French Landing Suite 300
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

LP/G3076269/RC

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider to</u>:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records</u>.**

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER:_____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(____)_____ **(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.
1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:
1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)
YB/G6019027/RTK-ms.70